		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041780

Facility Name: ROSE GARDEN CONVALESCENT CTR

Address: 1629 GARDEN LANE (Number) PEORIA HEIGHTS (City) 61614 (Zip Code)

County: PEORIA

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 39-4069174

Date of Initial License for Current Owners: 03/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,130	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	110	TOTALS	110	40,260	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,336	3,336	8
9	SNF/PED					9
10	ICF	21,906	1,246		23,152	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,906	1,246	3,336	26,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 3,336

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,837	16,472	6,323	181,632		181,632		181,632			1
2	Food Purchase		124,992		124,992	(21,411)	103,581	(278)	103,303			2
3	Housekeeping	106,663	24,041		130,704		130,704		130,704			3
4	Laundry	41,422	9,337		50,759		50,759		50,759			4
5	Heat and Other Utilities			75,151	75,151		75,151	367	75,518			5
6	Maintenance	28,488	30,355	19,332	78,175		78,175	3,738	81,913			6
7	Other (specify):*			6,760	6,760		6,760	193	6,953			7
8	**TOTAL General Services**	335,410	205,197	107,566	648,173	(21,411)	626,762	4,020	630,782			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,122,731	53,565	5,148	1,181,444		1,181,444	14,111	1,195,555			10
10a	Therapy	42,824	5,839	108,166	156,829		156,829	(59,937)	96,892			10a
11	Activities	42,924	673		43,597		43,597		43,597			11
12	Social Services	26,813		1,841	28,654		28,654		28,654			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,235,292	60,077	121,155	1,416,524		1,416,524	(45,826)	1,370,698			16
	C. General Administration											
17	Administrative	60,131			60,131		60,131	37,829	97,960			17
18	Directors Fees											18
19	Professional Services			71,683	71,683		71,683	(9,910)	61,773			19
20	Dues, Fees, Subscriptions & Promotions			26,289	26,289		26,289	(10,787)	15,502			20
21	Clerical & General Office Expenses	133,931	13,729	129,898	277,558		277,558	(43,115)	234,443			21
22	Employee Benefits & Payroll Taxes			238,637	238,637	21,411	260,048		260,048			22
23	Inservice Training & Education			750	750		750	679	1,429			23
24	Travel and Seminar			167	167		167	223	390			24
25	Other Admin. Staff Transportation			2,927	2,927		2,927	2,254	5,181			25
26	Insurance-Prop.Liab.Malpractice			77,990	77,990		77,990	1,418	79,408			26
27	Other (specify):*							25,007	25,007			27
28	**TOTAL General Administration**	194,062	13,729	548,341	756,132	21,411	777,543	3,598	781,141			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,764,764	279,003	777,062	2,820,829		2,820,829	(38,208)	2,782,621			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: ROSE GARDEN CONVALESCENT CTR #0041780 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,816	
	REPAIRS & MAINTENANCE		507	
			0	6,323
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		26,487	
	ELECTRICITY		32,653	
	WATER		8,481	
	CABLE TV - LOBBY		7,530	
			0	75,151
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,995	
	PAINTING & DECORATING		754	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,706	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,640	
	FIRE SERVICE		2,237	
			0	
			0	
			0	19,332
7	**OTHER**			
	SCAVENGER		6,760	
	SECURITY SERVICE		0	6,760
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	78	
	PHARMACY CONSULTANT	XVIII B 39-2	570	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B 40-2	4,500	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	5,148
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		25,399	
	SPEECH THERAPY SERVICES		4,091	
	OCCUPATIONAL THERAPY SERVICES		24,746	
	THERAPY CONTRACT SERVICES		43,130	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	108,166
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,841	
			0	1,841
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR #0041780 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,962	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	49,721	
			0	71,683
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,778	
	EMPLOYEE WANT ADS	XIX F	11,039	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	37	
	LICENSES & PERMITS	XIX F	2,758	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	7,615	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	12	26,289
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		9,207	
	EQUIPMENT REPAIR & MAINTENANCE		5,342	
	OUTSIDE CLERICAL SERVICES		66,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	33,831	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		13,381	
	MESSENGER SERVICE		2,137	
			0	129,898

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	133,715	
	UNEMPLOYMENT COMPENSATION	XIX D	39,502	
	WORKERS COMPENSATION INSURANCI	XIX D	48,276	
	HOSPITALIZATION INSURANCE	XIX D	15,420	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,621	
	EMPLOYEE PHYSICAL EXAMS	XIX D	103	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	238,637
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		750	750
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	167	
			0	
			0	167
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,927	2,927
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		77,990	77,990
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 777,062

ROSE GARDEN CONVALESCENT CTR
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	124,992	PATIENT MEALS	79464
LESS SALES TAX	(278)	ADD EMPLOYEE MEALS	16470
NET FOOD	124,714	TOTAL MEALS/YEAR	95934
TOTAL PATIENT CENSUS	26,488	NET FOOD	124714
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	95934
TOTAL PATIENT MEALS	79464	COST PER MEAL	1.3
		TIME EMPLOYEE MEALS	16470
ADD # EMPLOYEE MEALS/DAY	45		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	21411
TOTAL EMPLOYEE MEALS	16470		

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR #0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,772	3,772		3,772	119,951	123,723			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,538	49,538		49,538	212,037	261,575			32
33	Real Estate Taxes			65,706	65,706		65,706		65,706			33
34	Rent-Facility & Grounds			361,514	361,514		361,514	(358,175)	3,339			34
35	Rent-Equipment & Vehicles			95,983	95,983		95,983	(30,804)	65,179			35
36	Other (specify):*											36
37	**TOTAL Ownership**			576,513	576,513		576,513	(56,991)	519,522			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,537	156,772	254,309		254,309	(149,584)	104,725			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,390	60,390		60,390		60,390			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		97,537	217,162	314,699		314,699	(149,584)	165,115			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,764,764	376,540	1,570,737	3,712,041		3,712,041	(244,783)	3,467,258			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,223	30		9
10	Interest and Other Investment Income	(28,091)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(278)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(33,831)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,778)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,615)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,420)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(176,363)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (176,363)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (244,783)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ROSE GARDEN CONVALESCENT CTR

ID# 0041780

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(278)	0	0	0	0	0	0	0	0	0	0	(278)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	367	0	0	0	0	0	0	0	0	367	5
6	Maintenance	0	0	3,738	0	0	0	0	0	0	0	0	3,738	6
7	Other (specify):*	0	0	193	0	0	0	0	0	0	0	0	193	7
8	**TOTAL General Services**	(278)	0	4,298	0	0	0	0	0	0	0	0	4,020	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	14,111	0	0	0	0	0	0	0	0	14,111	10
10a	Therapy	0	(61,801)	1,864	0	0	0	0	0	0	0	0	(59,937)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(61,801)	15,975	0	0	0	0	0	0	0	0	(45,826)	16
	C. General Administration													
17	Administrative	0	0	37,829	0	0	0	0	0	0	0	0	37,829	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(12,000)	2,090	0	0	0	0	0	0	0	0	(9,910)	19
20	Fees, Subscriptions & Promotions	(12,443)	0	1,656	0	0	0	0	0	0	0	0	(10,787)	20
21	Clerical & General Office Expenses	(33,831)	(66,000)	56,716	0	0	0	0	0	0	0	0	(43,115)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	679	0	0	0	0	0	0	0	0	679	23
24	Travel and Seminar	0	0	223	0	0	0	0	0	0	0	0	223	24
25	Other Admin. Staff Transportation	0	0	2,254	0	0	0	0	0	0	0	0	2,254	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,418	0	0	0	0	0	0	0	0	1,418	26
27	Other (specify):*	0	0	25,007	0	0	0	0	0	0	0	0	25,007	27
28	**TOTAL General Administration**	(46,274)	(78,000)	127,872	0	0	0	0	0	0	0	0	3,598	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(46,552)	(139,801)	148,145	0	0	0	0	0	0	0	0	(38,208)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,223	108,285	5,443	0	0	0	0	0	0	0	0	119,951	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,091)	224,513	15,615	0	0	0	0	0	0	0	0	212,037	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(361,514)	3,339	0	0	0	0	0	0	0	0	(358,175)	34
35	Rent-Equipment & Vehicles	0	(34,426)	3,622	0	0	0	0	0	0	0	0	(30,804)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,868)	(63,142)	28,019	0	0	0	0	0	0	0	0	(56,991)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(149,584)	0	0	0	0	0	0	0	0	0	(149,584)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(149,584)	0	0	0	0	0	0	0	0	0	(149,584)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(68,420)	(352,527)	176,164	0	0	0	0	0	0	0	0	(244,783)	45

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CAREPLUS MGMT	NILES	MGMT/CLERICAL
				ROSE GARDEN CARE CENTER LLC		REAL ESTATE
					NILES	
				CAREPLUS REHABILITATIVE SERVICES		THERAPY
					NILES	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 361,514	ROSE GARDEN CARE CENTER LLC		$	$ (361,514)	1
2	V	30	SL DEPRECIATION		" "		108,285	108,285	2
3	V	32	INTEREST		" "		224,513	224,513	3
4	V								4
5	V								5
6	V	19	DATA PROCESSING FEES	12,000	CAREPLUS MGMT INC			(12,000)	6
7	V	21	CLERICAL FEES	66,000	" "			(66,000)	7
8	V								8
9	V								9
10	V	10a	THERAPY SERVICES	68,740	CAREPLUS REHABILITATIVE SERVICES		6,939	(61,801)	10
11	V	39	ANCILLARY THERAPY	178,844	" "		29,260	(149,584)	11
12	V	35	EQUIPMENT RENT	34,426	" "			(34,426)	12
13	V								13
14	Total			$ 721,524			$ 368,997	$ * (352,527)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC	100.00%	$	$	15
16	V	5	UTILITIES		" "		367	367	16
17	V	6	MAINT & REPAIRS		" "		13	13	17
18	V	6	MAINTENANCE SALARIES		" "		3,725	3,725	18
19	V	7	SECURITY		" "		193	193	19
20	V	10	NURSING SALARIES		" "		14,111	14,111	20
21	V	10a	THERAPY SALARIES		" "		1,864	1,864	21
22	V	17	ADMIN SALARIES		" "		37,829	37,829	22
23	V	19	PROFESSIONAL FEES		" "		2,090	2,090	23
24	V	20	ADVERTISING		" "		1,656	1,656	24
25	V	21	OFFICE EXPENSE		" "		18,346	18,346	25
26	V	21	OFFICE SALARIES		" "		38,370	38,370	26
27	V	23	SEMINARS		" "		679	679	27
28	V	24	TRAVEL		" "		223	223	28
29	V	25	TRANSPORTATION		" "		2,254	2,254	29
30	V	26	INSURANCE		" "		1,418	1,418	30
31	V	27	EMPLOYEE BENEFITS		" "		25,007	25,007	31
32	V	30	DEPRECIATION		" "		5,443	5,443	32
33	V	32	INTEREST		" "		15,615	15,615	33
34	V	34	OFFICE RENT		" "		3,339	3,339	34
35	V	35	EQUIPMENT RENT		" "		3,622	3,622	35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 176,164	$ * 176,164	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	JAKOB BAKST	DIR OF OPERATIO	ADMIN,CONSULT		SEE ATTACHED			SALARY	8,664	17-7	2
3	SHERWIN I. RAY	PRESIDENT	ADMIN,FINANCE		SCHEDULES			SALARY	8,664	17-7	3
4	JAMEE O'BRIEN	REGIONAL MGMT	ADMINISTRATION		" "			SALARY	6,201	17-7	4
5	JOE ANN BREW	REGIONAL MGMT	ADMINISTRATION		" "			SALARY	3,462	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,991		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MGMT
Street Address: 8320 SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	451,049	9	$ 26,990	$ 26,990		$ 0	1
2	5	UTILITIES	" "	565,586	13	7,834		26,488	367	2
3	6	MAINT & REPAIRS	" "	565,586	13	275		26,488	13	3
4	6	MAINTENANCE SALARIES	" "	565,586	13	79,548	79,548	26,488	3,725	4
5	7	SECURITY	" "	565,586	13	4,112		26,488	193	5
6	10	NURSING SALARIES	" "	565,586	13	301,295	301,295	26,488	14,111	6
7	10a	THERAPY SALARIES	" "	565,586	13	39,798	39,798	26,488	1,864	7
8	17	ADMIN SALARIES	" "	565,586	13	807,745	807,745	26,488	37,829	8
9	19	PROFESSIONAL FEES	" "	565,586	13	44,637		26,488	2,090	9
10	20	ADVERTISING	" "	565,586	13	35,362		26,488	1,656	10
11	21	OFFICE EXPENSE	" "	565,586	13	391,736		26,488	18,346	11
12	21	OFFICE SALARIES	" "	565,586	13	819,289	819,289	26,488	38,370	12
13	23	SEMINARS	" "	565,586	13	14,490		26,488	679	13
14	24	TRAVEL	" "	565,586	13	4,769		26,488	223	14
15	25	TRANSPORTATION	" "	565,586	13	48,136		26,488	2,254	15
16	26	INSURANCE	" "	565,586	13	30,286		26,488	1,418	16
17	27	EMPLOYEE BENEFITS	" "	565,586	13	533,964		26,488	25,007	17
18	30	DEPRECIATION	" "	565,586	13	116,219		26,488	5,443	18
19	32	INTEREST	" "	565,586	13	333,416		26,488	15,615	19
20	34	OFFICE RENT	" "	565,586	13	71,288		26,488	3,339	20
21	35	EQUIPMENT RENT	" "	565,586	13	77,344		26,488	3,622	21
22										22
23										23
24										24
25	TOTALS					$ 3,788,533	$ 2,074,665		$ 176,164	25

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: ROSE GARDEN CENTER LLC						$	$			$	1
2	AMERICAN NATIONAL BANK		X	MORTGAGE	$28,571.00	09/98	3,600,000	2,964,414	08/2018	7.2100	222,171	2
3	CIB		X	CAPITAL IMPROV LOAN			90,000	33,843			2,342	3
4												4
5												5
	Working Capital											
6	SHAREHOLDER/PARTNER	X		WORKING CAPITAL				540,000			49,538	6
7												7
8	RELATED PARTY										15,615	8
9	TOTAL Facility Related				$28,571.00		$ 3,690,000	$ 3,538,257			$ 289,666	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,690,000	$ 3,538,257			$ 289,666	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 60,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 62,206	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,206	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 63,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 65,706	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	50,679	8
	2000	51,837	9
	2001	53,993	10
	2002	58,259	11
	2003	62,206	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROSE GARDEN CONVALESCENT CTR COUNTY PEORIA

FACILITY IDPH LICENSE NUMBER 0041780

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-15-426-004	NURSING HOME	$ 62,205.90	$ 62,205.90
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,205.90	$ 62,205.90

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior CEMENT BLOCK Frame METAL BEAM Number of Stories 1 - NO BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	400,860	1998	$ 126,500	1
2					2
3	TOTALS	400,860		$ 126,500	3

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: ROSE GARDEN CARE CENTER LLC				$	$		$	$	$	4
5	110		1998		2,536,069	65,025	39	65,025		409,145	5
6					884,255	22,672	39	22,672		199,353	6
7											7
8	RELATED PARTY					55		55			8
	Improvement Type**										
9	COOLER DOOR			1996	1,675	43	39		(43)		9
10	LIGHTING			1997	2,293	59	39		(59)		10
11	PARKING LOT REPAIRS			1998	3,628	242	15		(242)		11
12	BUMPERS/HANDRAILS/ORNAMENTAL RAILING			1999	17,449	447	39		(447)		12
13	CARPET			2000	2,677	97	27.5		(97)		13
14	FENCING			2001	1,513	55	27.5		(55)		14
15	WATER HEATER			2003	10,051	167	27.5		(167)		15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,459,610	$ 88,862		$ 87,752	$ (1,110)	$ 608,498	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 29,950	$ 2,424	$ 2,896	$ 472	10 YRS	$ 16,342	71
72	Current Year Purchases	2,245	1,348	112	(1,236)	10 YRS	112	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	275,745	24,866	32,963	8,097			74
75	TOTALS	$ 307,940	$ 28,638	$ 35,971	$ 7,333		$ 16,454	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,894,050	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,500	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,723	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,223	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 624,952	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 95,983 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 65,808	$		$ 65,808	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,123			13,123	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			60,489			60,489	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				91,923		91,923	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES,RADIOLOGY Other (specify):	39-2				17,352	5,614		22,966	13
14	TOTAL			$		$ 156,772	$ 97,537		$ 254,309	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	1,619,381		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,228		6
7	Other Prepaid Expenses	14,439		7
8	Accounts Receivable (owners or related parties)	406,746		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,079,794	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	32,195		16
17	Accumulated Depreciation (book methods)	(28,985)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,210	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,083,004	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 689,441	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,197		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,315		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,500		32
33	Accrued Interest Payable	239,636		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,101,089	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	591,103		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 591,103	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,692,192	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 390,812	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,083,004	$	48

*(See instructions.)

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 768,783	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	1,556	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 770,339	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(379,527)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (379,527)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 390,812	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,303,887	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,303,887	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	536	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 536	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28,091	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,091	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,332,514	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	648,173	31
32	Health Care	1,416,524	32
33	General Administration	756,132	33
	B. Capital Expense		
34	Ownership	576,513	34
	C. Ancillary Expense		
35	Special Cost Centers	254,309	35
36	Provider Participation Fee	60,390	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,712,041	40
41	**Income before Income Taxes (line 30 minus line 40)****	(379,527)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (379,527)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,517	2,716	$ 57,479	$ 21.16	1
2	Assistant Director of Nursing	1,344	1,377	47,416	34.43	2
3	Registered Nurses	7,759	7,988	198,946	24.91	3
4	Licensed Practical Nurses	17,114	17,220	344,533	20.01	4
5	Nurse Aides & Orderlies	43,796	45,207	474,357	10.49	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,566	6,747	42,824	6.35	8
9	Activity Director	2,027	2,143	21,044	9.82	9
10	Activity Assistants	2,052	2,254	21,880	9.71	10
11	Social Service Workers	1,604	1,667	26,813	16.08	11
12	Dietician					12
13	Food Service Supervisor	2,466	2,675	39,561	14.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,089	14,716	119,276	8.11	15
16	Dishwashers					16
17	Maintenance Workers	1,920	2,111	28,488	13.50	17
18	Housekeepers	12,933	13,459	106,663	7.93	18
19	Laundry	5,412	5,626	41,422	7.36	19
20	Administrator	3,897	4,132	60,131	14.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,336	9,971	133,931	13.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,832	140,009	$ 1,764,764 *	$ 12.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,816	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	78	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	570	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	1,841	12-3	45
46	Other(specify) PSYCHIATRIC	S	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,605		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STELLA DURDLE	ADMIN		$ 60,131
DAWN MAY	ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,131

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$ 0
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK BOKOR KAGDA	ACCOUNTING	$ 28,850
MAYER MAGENCE	LEGAL	12,361
SACHNOFF & WEAVER	LEGAL	731
RICHARD PEELO	MEDICARE CONSULTANT	4,800
P.K. BHOSALE	LIFE SAFETY SURVEY	880
PERSONNEL PLANNERS	UC CONSULTANT	2,099
CAREPLUS MGMT	DATA PROCESSING	12,000
AMERICAN DATA	DATA PROCESSING	2,785
E-HEALTH DATA SOLUTIONS	DATA PROCESSING	825
NATIONAL DATA CARE CORP	DATA PROCESSING	2,355
ACHIEVE HEALTHCARE	DATA PROCESSING	3,997
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 71,683

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 48,276
Unemployment Compensation Insurance		39,502
FICA Taxes		133,715
Employee Health Insurance		15,420
Employee Meals		21,411
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,621
EMPLOYEE PHYSICAL EXAMS		103
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 260,048

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,100
Advertising: Employee Recruitment	11,039
Health Care Worker Background Check	12
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	12,393
TRUST/FRANCHISE/CONTRIB/ETC	50
LICENSES & PERMITS	658
DUES & SUBSCRIPTIONS	37
MGMT CO ALLOCATION	1,656
TRUST/FRANCHISE/CONTRIB/ETC	(50)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,778)
Yellow page advertising	(7,615)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,502

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	167
Seminar Expense	
	0
MGMT CO ALLOCATION	223
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 390

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$ 0	$	$	$	$	$

Facility Name & ID Number ROSE GARDEN CONVALESCENT CTR # 0041780 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,705** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,390**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,411** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees